Employee Benefits Corporation

The BESTflex℠ Plan

Section 125 Administration

Reimbursement Form

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For each Dependent Care FSA claim, the provider signature certifies the services provided and replaces the need for a receipt or other proof of service.

My Personal Information:

☐ **Check if any Personal Information is new or changed**

Participant Name | Middle Initial | Last Name

Mailing Address | City | State | Zip

Company Name | E-mail Address (We do not share your e-mail address) | Social Security Number (___ – ___ – ____)

*It takes **three business days** for us to process your claim.*
Please allow that much time to pass before viewing your claim's status at www.ebcflex.com.

Health Care FSA Claim Detail:

Date of Service (mm/dd/yyyy)	Type of Service	Name of Provider	Claim Amount

Dependent Care FSA Claim Detail:

From: to:

Service Dates (mm/dd/yyyy to mm/dd/yyyy)	Type of Service	Name of Provider	Claim Amount

Provider Signature (certifies services provided; replaces the need for a receipt or other proof of service) | Tax ID or Social Security Number | Date (mm/dd/yyyy)

From: to:

Service Dates (mm/dd/yyyy to mm/dd/yyyy)	Type of Service	Name of Provider	Claim Amount

Provider Signature (certifies services provided; replaces the need for a receipt or other proof of service) | Tax ID or Social Security Number | Date (mm/dd/yyyy)

Reimbursement Authorization:

This is to certify that my statements on this Reimbursement Form are complete and true. I am claiming reimbursement only for eligible expenses incurred during the applicable plan year and for my eligible dependents. I understand that it is my responsibility to submit only eligible expenses defined by My Company Plan's parameters. I certify that these expenses have not been, nor will be, reimbursed by any other benefit plan and will not be claimed as an income tax deduction. I also understand, to provide services to my employer in connection with one or more employee benefit plans maintained by my employer, Employee Benefits Corporation may need "protected health information" regarding coverage or benefits for me or my dependents under the plan. By signing this Reimbursement Form, I hereby acknowledge that Employee Benefits Corporation will obtain and use such information and disclose it to my employer (or to an insurer or other provider of services related to the plan), but only for the purposes of the plan and only for as long as Employee Benefits Corporation is providing services regarding the plan. Any information disclosed pursuant to this Reimbursement Form will not be subject to redisclosure by the recipient, except for purposes of the plan. **I understand that my claim will be denied if I do not sign this form.**

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Total amount of reimbursement requested | **Date (mm/dd/yyyy)**

X

Account Holder's Signature (Must be signed by account holder)

Helpful Hints To Ensure Speedy Processing:

- Make a photocopy of this form
- **Please print**
- Fill out form completely
- Staple all documents to the upper left corner of this form and mail to:
  Employee Benefits Corporation
  PO Box 44347
  Madison WI 53744-4347
- Or fax form and attachments to Employee Benefits Corporation at:
  608 831 4790
- When faxing, remember to fax copies of your bill or receipt, or Explanation of Benefits (EOB) for deductibles
- Retain original copies of this form and documentation for your files; Reimbursement Forms, receipts and claims information cannot be returned
- Sign and date this Reimbursement Form; we will not process unsigned or undated forms
- Attach a copy of your Explanation of Benefits (EOB) for deductibles and coinsurance; for other eligible medical expenses you may submit the bill or receipt
- Documentation must include date(s) of services, type of expense, amount of expense and name of service provider
- Documentation must include date(s) of services, type of expense, amount of expense and name of service provider
- There is a $25.00 stop payment fee charged if we must reissue a lost reimbursement check

Web Address:
www.ebcflex.com

U.S. Mail:
Employee Benefits Corporation
PO Box 44347
Madison WI 53744-4347

Phone:
Monday - Friday, 8:00 - 5:00 CST
608 831 8445
800 346 2126

Fax:
608 831 4790

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